DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 3/19/11

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445288	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTSVILLE MANOR	287 BAKER STREET HUNTSVILLE, TN 37756

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS During the Life Safety portion of the survey conducted on February 2, 2011, no deficiencies were cited under 42CFR Part 483 Requirements for Long Term Care Facilities.	K 000	N833 1200-8-6-.08(3) Building Standards Corrective action(s) accomplished for those residents found to have been affected by the deficient practice; 1. Letter requesting approval from the Department of Health for the modification of kitchen hood suppression system submitted by Administrator on February 14, 2011. Completion date: 2/14/11 Identify other residents having the potential to be affected by the same deficient practice and what corrective action taken: 2. Full inspection completed in the kitchen by Maintenance and Risk Manager assuring that all equipment is in compliance with State and Federal Regulations. Completed on: 2/14/11 Measures/systematic changes put in place to ensure the deficient practice does not recur; 3. In-service completed by Administrator with Maintenance Director for any modifications within the buidling must be prior approved and State notification to be made. Completion date: 2/14/11 Kitchen inspections conducted monthly and reviewed at Safety Committee (NHA, DON, Maintenance Director, Dietary Manager, Housekeeping Supervisor, and Rehab Director) meeting for compliance with building standards.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lara Buttram	Administrator	2-15-11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.